

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
<http://www.dail.vermont.gov>
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 25, 2018

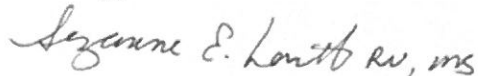
Eileen Whalen, Administrator
University Of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

Dear Ms. Whalen:

The Division of Licensing and Protection completed a complaint investigation at your facility on July 13, 2018. The purpose of the investigation was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482. This investigation found that your facility was in substantial compliance with the participation requirements.

Please sign the enclosed CMS-2567 and return to this office by August 8, 2018 .

Sincerely,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/13/2018
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 000	<p>INITIAL COMMENTS</p> <p>An unannounced on-site survey was completed on 7/13/18 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The purpose of the visit was to conduct a monitoring review visit (#16818) and a complaint investigation (16819). There were no regulatory violations found.</p>	A 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Coneokey

TITLE

Director

(X6) DATE

7/27/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.